	SELECTED HEALTH PLAN OPTION	
Employee/Dependent Name	Plan:	Additional Retiree Options – Over 65:
Address	EPO □ RAN/AMN □ Schaller Anderson Healthcare □ United HealthCare	☐ United HealthCare☐ PacifiCare
Phone	PPO □ AZ Foundation	
Employee #	☐ United HealthCare ☐ Beech Street	

You should apply for TOC assistance if you answer "Yes" to any question below, Even if your doctor is participating in your new network.

TRANSITION OF CARE FORMS

Please provide complete information to assure timely administration of TOC. Information provided will not cause medical plan enrollment denial. This information is for the Transition Team and your Health Plan only. This information will not be shared with your employer.

Please fill out a separate request form for each covered member:

PLEASE CHECK ALL THAT APPLY

Have you received or been evaluated for a transplant?	\square Yes	\square No
Are you in the last 6 months of pregnancy or did you deliver less than 6 weeks ago?	\square Yes	\square No
Have you ever had a "High Risk Pregnancy"?	\square Yes	\square No
Are you currently undergoing radiation or chemotherapy for cancer?	\square Yes	\square No
Are you undergoing active treatment for Immunosuppressive Disorder?	\square Yes	\square No
Are you being actively treated for severe or end stage kidney disease?	\square Yes	\square No
Are you currently undergoing dialysis?	\square Yes	\square No
Have you had any procedure/surgery performed during the last 6 weeks?	\square Yes	\square No
Do you have any procedure/surgery scheduled in the next 3 months?	\square Yes	\square No
Have you been hospitalized in the past 6 weeks? Please check below.	\square Yes	\square No
☐ Hospital. If yes, Discharge date		
☐ Skilled Nursing Facility. If yes, Discharge date		
☐ Behavioral Health/Substance Abuse center. If yes, Discharge date		
☐ Acute Rehabilitation center. If yes, Discharge date		
Are you under the care of Hospice?	\square Yes	\square No
Are you receiving any of the following therapies either in your home or as an		
outpatient: Physical Therapy, Occupational Therapy or Speech Therapy?	\square Yes	\square No
Are you receiving Home Health care?	□ Yes	□No

Are you receiving home IV infusion or outpatient infusion therapies,					
for example, blood transfusions or antibiotic therapy?			\square No		
Are you using any DME (Durable Medical Equipment), for example,	wheelchair,				
walker, crutches, oxygen, B-Pap machine, SVN breathing machine?			\square No		
Are you currently assigned to a Case Manager? (Check below)		\square Yes	\square No		
☐ Medical Case Management ☐ Behavioral Case Management					
Are you being treated for a worker's compensation injury?			\square No		
Are you receiving treatment for behavioral health/substance abuse issues?			\square No		
Are you receiving anticoagulant (blood thinner) therapy?			\square No		
Are you currently under the care of a physician for any of the following any of the following:	g conditions or have you b	een diagn	osed with		
□ Asthma	☐ MS (Multiple Sclerosi	is)			
☐ Diabetes Mellitus	☐ ALS (Amyotrophic La	ateral Scle	rosis-		
☐ CHF (Congestive Heart Failure)	Lou Gehrig's Disease	e)			
☐ COPD (Chronic Obstructive Pulmonary	☐ CP (Cerebral Palsy)				
Disease)	☐ Autoimmune Diseases	3			
☐ CAD (Coronary Artery Disease)	☐ Migraines				
□ Pain Management	☐ A-Fib (Atrial Fibrillation)				
☐ CVA (Cerebral Vascular Accident) ☐ Eye diseases/Glaucor		ıa			
☐ TIA (Transient Ischemic Accident)					
☐ HTN (Hypertension)					
□ Pacemaker□ Other					
For every item that you marked please supply the following inform	nation:				
Condition / Date Treatment Started / Dr. Name & A	Address / Dr. Phone Number	er			
Example: Asthma / Jan 1999 / Dr. Jones, 1234 E Any Street / 602-789-1234					
1					
2					
3					
4					
5					
6					
7					
8					

Employee/Dependent Name	
Phone	
Employee #	
MEDICATION TRANSITION	ON OF CARE
Are you using self-injectable medication? Do you take medications which involve the prior authorization process (where your physician requests receives approval for an exempt of coverage)? If yes, list:	
SPECIALTY PHARMACY ME	DICATIONS
Please check the box(es) if you have any of these conditions and are taking any of these medications. Acromegaly (e.g. Sandostatin) Anticoagulants (e.g. Lovenox) Asthma (e.g. Xolair) Biologic Response Modifiers (i.e. Amevive, Enbrel, Remicade) Blood Modifiers (e.g. Procrit, Neupogen) Biologic Response Modulator (e.g. Proleukine) Chronic Granulamatous (e.g. Actimmune) Condylomata Acuminata (e.g. Alferon) Cystic Fibrosis (e.g. Pulmozyme, Tobi) Endometriosis (e.g. Lupron, Syranel) Enzyme Replacement (e.g. Fabrazyme, Cerezyme) Growth Hormones (e.g. Genotropin, Humatrope) Hemophilia (e.g. Recombinate) Immunoglobulins (e.g. Gamimune) Multiple Sclerosis (e.g. Avonex, Betaseron) Osteoarthritis (e.g. Synvisc) or Osteoporosis (e.g. Forteo) Precocious Puberty (e.g. Lupron Depot Pediatric) Prostate Cancer (e.g. Lupron Depot, Viadur) Respiratory Syncytial Virus (e.g. Synagis) Viral Hepatitis (e.g. Peg-Intron)	Name of Medication
Limited Distribution Drugs:	
 □ Acromegaly (Somavert) □ Alpha-1 deficiency (Aralast, Prolastin, Zamaira) □ Cateplexy in patients with Narcolepsy (Xyrem) □ Primary Pulmonary Hypertension (Flolan, Remodulin, Tracleer) 	
List name of the pharmacy where you are obtaining any of the ab	ove medications:
Med Name Pharmacy Name	Location Phone